Committee on Energy & Commerce
Subcommittee on Oversight and Investigations
"Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse"
6/25/14

HHS OIG QFR Responses – submitted 8/1/14

The Honorable Tim Murphy

1. CMS says the Fraud Prevention System (FPS) "prevented more than $210 million in improper Medicare fee-for-service payments, double the previous year." But according to the OIG's comments in the report, OIG only certified $54.2 million of actual savings in the Medicare program. Can you please explain why CMS is claiming higher numbers than OIG says may be verifiable?

Answer:

Both the identified amount of $210.7 million and the adjusted savings amount of $54.2 million are verifiable. The $210.7 million represents how much the FPS identified through administrative actions. However, the $210.7 million does not represent funds actually returned to, or prevented from leaving, the Medicare Trust Fund. CMS determined its FPS estimate on the basis of how much the FPS identified regardless of whether that full amount will be returned to, or prevented from leaving, the Trust fund. However, our adjusted savings amount provides a more accurate estimate of the dollars that the Department of Health and Human Services (the Department) has already returned, or is likely to return in the future, from the identified or unadjusted savings.

For example, the FPS may have targeted providers for investigations that resulted in the Zone Program Integrity Contractors and Program Safeguard Contractors (contractors) calculating overpayments of $10 million. However, we would only certify the portion of that overpayment that can reasonably be expected to be recovered based on historical data for the collection of overpayments when identified by the contractors. We define "certify" to mean a determination that the Department reported actual and projected savings and its return on investment that were reasonably estimated.

2. At the end of the OIG's report on the FPS, there is some extended discussion between CMS and OIG regarding two issues: (1) contractors being given written instructions to determine when savings from an administrative action should be attributed to the FPS, and (2) requiring contractors to maintain documentation supporting the claim that an FPS lead contributes to an administrative action. Can you briefly outline your recommendations, CMS's perspective, and what you think should happen now? OAS

Answer:

Summary of Recommendations

We recommended that the Department (1) provide its contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and (2) require contractors to maintain documentation to support how the FPS lead contributes to an administrative action. That is, we wanted CMS to issue written instructions to the contractors clearly delineating how the contractors should document the contribution of the FPS lead to the investigation and achievement of the administrative action.

CMS' Perspective and OIG's Position

Despite the extended discussion in the comments section of our report, CMS concurred with both of our recommendations in its comments and stated that it "will issue a Technical Direction Letter" to the contractors that would provide "written instruction on how to determine whether an investigation initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation." CMS also stated it "will issue a Technical Direction Letter" to the contractors that would provide "written instructions on maintaining documentation when an FPS lead initiated a new investigation or corroborated, augmented, and/or expedited an existing investigation." CMS, however, also mentioned in its comments (1) the significance of identified savings versus adjusted savings and (2) the $39 million that we did not certify.

Identified Savings Versus Adjusted Savings

CMS' Perspective

According to CMS' second year report to Congress, the adjusted savings number is an attempt to estimate the dollars that CMS has or is likely to return to the Treasury from the larger category of identified savings. CMS also reports that the concept of adjusted savings is important for a financial audit but is of limited utility for determining the overall impact of the FPS and the purpose of the FPS which is to detect potential fraud. Thus, CMS believes that identified savings is a more meaningful measure of the impact of the FPS.

OIG's Position

The Small Business Jobs Act of 2010 requires that OIG certify actual and projected savings with respect to improper payments recovered and avoided. In this regard, the OIG reported that identified savings does not always result in the collection of overpayments or the avoidance of payments. In order to estimate how much of the identified savings would actually be collected or avoided, CMS applied its adjustment factors to the identified savings to determine the adjusted savings. Thus, the adjusted savings is a more accurate measure of the savings and return on investment for the Department's use of the FPS. As stated on page 8 of our report, "Identified savings does not represent a true return on investment because only a portion of those savings are returned to, or prevented from leaving, the Medicare Trust Funds."

The $39 Million That OIG Did Not Certify

CMS' Perspective

CMS asserts that outcomes resulting from existing investigations that were corroborated, augmented, and/or expedited by the FPS should be counted in the full value of savings and therefore, the OIG should have recognized and certified the $39 million in question.

OIG's Position

For our second year report, we did not recognize the $39 million as identified savings because, although there may have been an FPS lead related to the investigation, the contractors reported to us that the lead made no contribution to achievement of the administrative action. If the contractors demonstrated and documented that the FPS made an actual contribution to the investigation and the achievement of the administrative action then we would have attributed 100 percent of these savings to the FPS.

The OIG understands and agrees with CMS that investigations are fluid and dynamic and that investigators need to work a case using all available information. If investigators are required to allocate the results of an investigation back to each piece of information in decision making, it would be extremely time consuming, completely subjective, and highly disruptive for the investigators. Therefore, we counted those administrative actions in the full value of identified savings.

However, if the FPS lead is said to "corroborate, augment, and/or expedite" an investigation, but the contractor could not demonstrate or document that the FPS lead actually contributed to the investigation or the contractor stated that the FPS lead had no impact on achieving the administrative action, we did not attribute these savings to the FPS.

NEXT STEPS

We have already begun contacting the contractors to discuss any written instructions that CMS provided to them to address our recommendations and how the contractors are documenting the contribution of the FPS in achieving any reportable savings.

For the third-year report, we will separately report the savings for which the FPS lead was able to "corroborate, augment, and/or expedite" an investigation if the investigators can document a contribution from the FPS lead in achieving the savings. These savings will be combined with savings from investigations initiated by FPS in calculating the certified ROI. However, OIG will continue to not recognize as identified savings administrative actions that result from an FPS lead that is said to corroborate, augment, and/or expedite an investigation if the contractors cannot demonstrate and document that the FPS made an actual contribution to achieving the administrative actions.

3. Some reports have noted that CMS has not published a proposed rule that would permit more disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment. How would such disclosure help fight fraud? For instance, would contractors that CMS currently works with- including Medicare Advantage and drug plan sponsors- be better able to identify fraudulent providers up front if they had access to such information?

Revised Question Received from Committee:

GAO has noted that CMS has not published a proposed rule that would permit more disclosure of prior actions against providers and suppliers that were enrolling or revalidating their Medicare enrollment (see Medicare: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts, GAO-14-619T). These disclosures would include whether or not the providers or suppliers had been subject to previous federal health care program suspensions. That's because § 6401(a) of the ACA requires providers and suppliers to disclose at initial enrollment or enrollment revalidation any current or previous affiliations with other providers or suppliers that have uncollected debt; has been subject to a federal health care program payment suspension; has been excluded from Medicare, Medicaid, or CHIP; or has had its billing privileges revoked. In OIG's opinion, would CMS's publishing a final rule and using (and allowing their contractors to use) the disclosure of prior actions against providers and suppliers be a useful step to reduce program vulnerabilities and fraud? For instance, would contractors that CMS currently works with—including Medicare Advantage and drug plan sponsors—be better positioned to identify improper payments or potentially fraudulent providers sooner if they had access to such information?

Answer:

It's possible, but there would be a number of factors to consider, such as the reliability of disclosures (e.g., entities intent on committing fraud might not adhere to a self-disclosure requirement and could enroll under an alias or name not associated with prior adverse actions) and how contractors and plans currently identify fraud. OIG has work underway, "Review of Enhanced Enrollment Screening Process for Medicare Providers," that might further inform this discussion, and would be happy to brief the Committee upon completion of the review.

4. The Centers for Medicare & Medicaid Services has agreed to postpone awarding the new round of Recovery Auditor Contractor (RAC) contracts until at least Aug. 15 because of pending litigation. This delay comes after numerous administrative changes and delays to the statutorily mandated program. Given the RACs record of recovering hundreds of millions, even billions, of dollars for the Medicare Trust Fund, does GAO have any concerns regarding the impact further administrative or legal delays may have on the effectiveness of the recoveries for the Medicare Trust Fund from this statutorily mandated program?

Answer:
OIG does not have a basis on which to opine on this question.

5. Do you believe the Medicare program would be more protected than it currently is if HHS OIG were given the authority to exclude a supplier/provider from federal health care programs once that individual has been convicted, instead of waiting for sentencing?

Answer:

By statute, the OIG has the authority to exclude an individual or entity from participation in federal health care programs at the time of conviction. At section 1128(i) of the Social Security Act defines a conviction for exclusion purposes as:
(i) Convicted Defined.—For purposes of subsections (a) and (b), an individual or entity is considered to have been "convicted" of a criminal offense—
(1) when a judgment of conviction has been entered against the individual or entity by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;
(2) when there has been a finding of guilt against the individual or entity by a Federal, State, or local court;
(3) when a plea of guilty or nolo contendere by the individual or entity has been accepted by a Federal, State, or local court; or
(4) when the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld.

Based on this definition, a subject could be excluded at the point a court accepts a plea agreement, accepts a verdict, or finds guilt. Historically, the OIG has excluded after sentencing as a matter of policy for two reasons:

- Many of the factors used to determine a reasonable period of exclusion are established only after sentencing. The majority of exclusion actions are derivative actions based on findings of a court or a state entity. The most significant factors to be considered in determining a reasonable period of exclusion, as listed in the OIG's regulations, are based on facts discovered at sentencing. Aggravating factors such as loss to the programs and incarceration, as well as the mitigating factors of mental incapacity and cooperation, factors common to most conviction-based exclusions, are more often than not determined only at the time of sentencing. These are important factors used in the determination of an appropriate period of exclusion.

- Documentation of action by various courts has, in many cases, not clearly indicated that a plea or verdict has been accepted by the court. For an exclusion action to be legally sufficient, the OIG must obtain documentation that clearly shows that the court accepted a plea or verdict or found the subject guilty. This documentation is usually not available, and sometimes not created, until sentencing.

6. Do you think it makes sense, from a program integrity perspective, for Congress to give HHS OIG or CMS more latitude to suspend, terminate, or otherwise exclude a supplier/provider from federal health care programs if that individual has been convicted of a felony?

Answer:

CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges based on conviction of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries. The examples set forth

in the relevant regulations, 42 CFR 424.535(a)(3), could provide a useful analogue in developing a proposal to expand OIG's exclusion authorities.

However, exclusion has a very broad effect, and requiring that the conviction or underlying conduct be tied to the delivery of a health care item or service could be viewed as a reasonable conscription of the exclusion authority. It also important to note that expansion of the exclusion statute in this way might not necessarily afford more protection to the programs, and could result in OIG needing to expend significant additional resources focusing on non-health care-related crimes and referrals.

OIG would welcome the opportunity to further discuss this and other proposals that would enhance OIG's enforcement authorities. Via separate technical assistance documents, OIG has provided recommendations to the Committee for improvements to the Civil Monetary Penalty Law and various exclusions authorities.

7. What do you believe are the top five vulnerabilities with regard to the integrity of Medicaid payments?

Answer:

OIG has identified Protecting the Integrity of an Expanding Medicaid Program as a Top Management Challenge for the Department.[1] One of the most significant vulnerabilities relating to ensuring the integrity of Medicaid payments is the lack of timely, accurate, complete national Medicaid data.[2] We have also uncovered significant problems when States game the system to artificially inflate their share of Federal matching funds and CMS does not act quickly to stop it. Additional areas of vulnerability include personal care services, Medicaid drug pricing, and Medicaid managed care. A fuller discussion of priority recommendations and related program vulnerabilities can be found in OIG's *Compendium of Priority Recommendations*.[3]

The Honorable Michael C. Burgess

1. What recommendations has the OIG made to CMS relating to improvements in the screening of providers or fund recipients that have not been adopted? Which ones have not been adopted? Has CMS given reasons for not adopting certain recommendations? What are those reasons?

Answer:

Report: *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600

[1] *2013 Top Management & Performance Challenges*, available at http://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge04.asp.
[2] *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System*, available at http://oig.hhs.gov/oei/reports/oei-05-12-00610.asp.
[3] Available at http://oig.hhs.gov/reports-and-publications/compendium/index.asp.

Recommendation:

CMS Should Strengthen the MEDIC's Monitoring of Pharmacies and Ability To Identify Pharmacies for Further Review

CMS Response:

CMS stated that it and the MEDIC would continue to refine data analysis on emerging trends and best available data. It also stated that it would consider the methodology used by OIG and explore approaches that could improve that methodology. In addition, CMS stated that the use of the pharmacy risk scores that the MEDIC is developing would strengthen the MEDIC's monitoring of pharmacies and ability to identify pharmacies for further review. Lastly, CMS stated that it reviews MEDIC data analysis at a weekly data analysis meeting to ensure the MEDIC monitors fraud at the pharmacy level. We believe that CMS's completed and planned actions would address the recommendation, when fully implemented. However, more documentation is needed. In its notification of final action, we request that CMS provide documentation explaining the analysis the MEDIC is conducting and the steps CMS has taken to strengthen this analysis, such as the weekly meeting.

Recommendation:

CMS Should Develop Risk Scores for Pharmacies

CMS Response:

CMS stated that a potential fraud risk assessment for pharmacies was completed on April 5, 2013. CMS also stated that it sent a Health Plan Management System (HPMS) memo to sponsors on June 21, 2013 that included a list of high risk pharmacies to assist plan sponsors in targeting pharmacies for audits and further analysis. The HPMS memo further stated that CMS plans to release a list of high risk pharmacies on a quarterly basis. We are supportive of the steps that CMS has taken to implement this recommendation. We believe this recommendation will be fully implemented when CMS begins to release the lists of high risk pharmacies on a routine or quarterly basis. We recommend that in its next release, CMS provide information to sponsors about why each pharmacy was identified as high risk. In its notification of final action, we request that CMS provide documentation that it is routinely providing these lists to sponsors.

Report: *Prescribers with Questionable Patterns in Medicare Part D*, OEI-02-09-00603

Recommendation:

CMS should instruct the MEDIC to expand its analysis of prescribers.

CMS Response:

CMS stated that it works continuously with the MEDIC to monitor prescribers and that the MEDIC has completed data analysis projects that make connections among the prescribers, pharmacies and beneficiaries. For example, the MEDIC completed a Health Care Fraud Prevention and Enforcement Action Team (HEAT) analysis. CMS stated that it will continue to work with the MEDIC to expand its analysis of prescribers. Additionally, CMS has increased its monitoring of prescribers through the Part D Recovery Audit Contractor. OIG does not believe that actions CMS described above fully address this recommendation. However, at the Medicare Parts C & D Fraud Work Group Webinar on January 9, 2014, CMS and the MEDIC announced that they are developing prescriber risk scores that take into account the prescriber's specialty and that they will provide lists of high risk prescribers to sponsors on an ongoing basis. We believe these actions would address the recommendation, when fully implemented. In its Notification of Final Action, we request that CMS provide documentation showing that the Part D sponsors have received a list of high risk prescribers.

Recommendation:

CMS should provide sponsors with additional guidance on monitoring prescribing patterns.

CMS Response:

CMS stated it conducted a virtual Fraud Waste and Abuse Work Group on June 18, 2013 for Part D plan sponsors in which drug overutilization was one topic on the agenda. CMS also stated that it will provide general guidance "red flags" to sponsors concerning aberrant and abusive prescribing patterns that it detects. In addition, CMS stated that it issued guidance to sponsors reiterating that their opioid overutilization programs are expected to include policies and procedures for referrals to appropriate agencies. CMS believes it is too early to implement additional guidance. We believe the actions described above do not fully address the recommendation. To fully implement this recommendation, CMS should issue additional guidance to sponsors about how to effectively monitor prescribers. For example, guidance on how sponsors should monitor the prescribers that CMS identifies as having a high risk score could implement this recommendation.

Report: *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608

Recommendation:

CMS should increase the MEDIC's monitoring of prescribers.

CMS Response:

CMS stated that the MEDIC is conducting proactive analysis to identify prescribers who do not have the authority to prescribe drugs and that the MEDIC will continue to monitor prescribers. In addition, CMS stated that it has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC). Further, CMS noted that the MEDIC completed an analysis of deceased prescribers and the RAC completed an analysis of excluded providers. We do not believe that the analyses of deceased and excluded

prescribers fully implement this recommendation. In its notification of final action, CMS should provide documentation of the results of the MEDIC's proactive analysis to identify prescribers who do not have authority to prescribe drugs.

Report: *Surety Bonds Remain an Underutilized Tool to Protect Medicare from Supplier Overpayments,* OEI-03-11-00350

Recommendation:

Improve oversight of supplier data to ensure accurate and consistent information.

CMS Response:

CMS implemented enhancements to the Provider Enrollment, Chain and Ownership System (PECOS) in January 2013 and July 2013. These enhancements include validation checks for dates and surety bond amounts entered in PECOS. In addition, contractors will now collect surety bond information at the associate and enrollment level. CMS did not concur with part of OIG's recommendation that it review all surety bond data within PECOS to identify other discrepancies or errors resulting from the transition from the Provider Information Management System to PECOS. CMS indicated that reviewing all PECOS fields was unnecessary because it and the National Supplier Clearinghouse conducted a thorough review of all currently enrolled DMEPOS suppliers and have verified that each entity, not otherwise exempt, is appropriately covered by a valid surety bond. OIG believes CMS's actions partially implement this recommendation. CMS's actions to enhance the PECOS system validation checks address part of this recommendation. However, because CMS does not plan to review all surety bond data within PECOS to identify discrepancies, as recommended, OIG will continue to consider this recommendation unimplemented. While OIG acknowledges CMS's efforts to ensure that DMEPOS suppliers are covered by valid surety bonds, this effort does not mean that the data discrepancies and errors we observed in the PECOS system have been addressed. OIG found numerous errors in PECOS as a result of the data system transition and continues to recommend that CMS conduct a quality check of the PECOS data to ensure that it is accurate, consistent, and accessible. OIG would consider this recommendation implemented when CMS provides additional documentation showing that quality checks of the PECOS data have been performed.

Report: *Vulnerabilities in CMS's and Contractors' Activities To Detect and Deter Fraud in Community Mental Health Centers,* OEI-04-11-00101

Recommendation:

CMS should develop a system to track revocation recommendations and improve revocation communication with contractors.

CMS Response:

In its final management decision, CMS stated that it established a set of guidelines for Zone Program Integrity Contractors (ZPICs) and Medicare Administrative Contractors (MACs) to ensure that revocation recommendations are addressed in a timely manner. These require ZPICs and MACs to submit revocation requests to a designated CMS revocation email mailbox. Additionally, CMS stated that it has developed and implemented a tracking system used by the revocation team which delineates revocation-specific duties, dates, and statuses. OIG believes that CMS's guidelines and tracking system are positive steps towards implementing this recommendation. For OIG to consider this recommendation fully implemented, we request that CMS provide documentation of ZPIC and MAC responses to the guidelines in its notification of final action. We also request that CMS provide further information about the revocation tracking system, such as standard operating procedures, and documentation of the functionality of the revocation email mailbox and the revocation tracking system.

Report: *Medicare Inappropriately Paid for Drugs Ordered By Individuals Without Prescribing Authority*, OEI-05-09-00608

Recommendation:

CMS should increase the MEDIC's monitoring of prescribers.

CMS Response:

CMS stated that the MEDIC is conducting proactive analysis to identify prescribers who do not have the authority to prescribe drugs and that the MEDIC will continue to monitor prescribers. In addition, CMS stated that it has increased its monitoring of prescribers through the Part D Recovery Audit Contractor (RAC). Further, CMS noted that the MEDIC completed an analysis of deceased prescribers and the RAC completed an analysis of excluded providers. We do not believe that the analyses of deceased and excluded prescribers fully implement this recommendation. In its notification of final action, CMS should provide documentation of the results of the MEDIC's proactive analysis to identify prescribers who do not have authority to prescribe drugs.

Recommendation:

CMS should ensure that Medicare does not pay for prescriptions from individuals without prescribing authority.

CMS Response:

CMS stated that current Prescription Drug Event (PDE) guidance provides Part D sponsors with a process to delete PDEs that are fraudulent. PDEs from prescribers confirmed by the MEDIC as not having prescribing authority would be communicated back to sponsors who would then delete the PDEs and implement point of sale edits to reject claims from these prescribers. CMS also cited a memorandum to sponsors entitled, Clarification of Recovery of Part D Payment for Pain Medications for Beneficiaries Enrolled in Hospice. We do not believe that the memorandum related to hospices addresses this recommendation. To fully implement this recommendation, CMS should issue guidance that requires sponsors to: 1)

review PDE records to verify that the prescriber is associated with a type of prescriber that has the authority to prescribe and 2) to submit adjustments and deletions when appropriate. CMS should also monitor sponsors' performance to make sure they are appropriately adjusting the PDE records.

Report: *Program Integrity Problems with Newly Enrolled Medicare Equipment Suppliers*, OEI-06-09-00230

Recommendation:

Apply investigative techniques and tools to identify any owners or managers of DMEPOS suppliers who are not reported on supplier applications as required.

CMS Response:

CMS stated it will implement measures to identify individuals affiliated with companies but not reported on enrollment documents. CMS will have its new screening contractor alert Medicare Administrative Contractors (MAC), including the National Supplier Clearinghouse (NSC) MAC, when individuals are identified through external referential data sources as having a managerial or ownership association with a supplier but not reported in the enrollment documents. OIG believes that CMS's planned actions, when fully implemented, will be sufficient to address this recommendation. In its notification of final action to the OIG, we request that CMS provide documentation of the new contractor actually conducting activities to identify owners and managers, the nature and results of those activities, transmissions of owner/manager information to the NSC-MAC, and enforcement/corrective actions, when appropriate.

Recommendation:

Take appropriate action regarding DMEPOS suppliers identified in the report that omit information from their applications.

CMS Response:

CMS stated that it was researching the list of 27 suppliers and would take action, if appropriate. As of June 11, 2012, CMS had determined 17 of the 27 suppliers were no longer in an approved status and 1 supplier had disclosed the missing information. For the remaining nine suppliers, CMS indicated that the NSC would either start the revalidation process or develop the missing information and take further administrative action as deemed appropriate. CMS indicated that it will also continue to refer to law enforcement for action at their discretion any additional individuals and suppliers identified as having inappropriately omitted required information on the enrollment application. OIG believes that the planned actions CMS described in its 2012 final management decision, when fully completed, would implement OIG's recommendation. In its notification of final action to the OIG, we request CMS provide evidence concerning the status of the remaining nine suppliers.

Report*: Inaccurate, Incomplete, and Inconsistent Provider Enumeration and Medicare Enrollment Data*, OEI-07-09-00440

Recommendation:

Require MACs to implement program integrity safeguards for Medicare provider enrollment as established in the PIM.

CMS Response:

CMS states that MACs must adhere to the processing guidelines established in the PIM. However, MACs reported to OIG that supplemental guidance waived their responsibility to verify data required by the PIM. It is not clear to OIG that MACs understand that they must verify all enrollment application data. CMS should remind MACs that they must verify all enrollment application data, and rescind supplemental guidance issued to expedite the processing of enrollment applications by verifying only select application data. In its notification of final action, CMS should provide evidence that they have informed MACs of their duty to verify all enrollment application data as required by the PIM.

Recommendation:

Require more verification of NPPES enumeration and PECOS enrollment data.

CMS Response:

CMS states that they are more rapidly deactivating National Provider Identifiers (NPIs) for deceased providers, and working to rapidly deactivate NPIs for invalid practice locations. OIG does not believe that either of these actions demonstrates more verification of NPPES or PECOS data at the time of application. CMS could use the new PECOS automated provider-screening tool to verify provider application data in NPPES, monitor NPPES applications by geographic area to detect potential fraud, and/or determine whether providers' locations are legitimate at the time they enroll in PECOS. In its notification of final action, CMS should provide documentation of additional verification of NPPES and PECOS application data.

Recommendation:

Detect and correct inaccurate and incomplete provider enumeration and enrollment data for new and established records.
CMS Response:

CMS states that changes to PECOS have increased the number of applications submitted online, and that recent system enhancements will decrease inaccurate and incomplete data. CMS plans to match enrollment data against public and private databases to minimize inaccurate and incomplete data, and encourage providers to update their records through an ongoing revalidation effort. We believe that CMS's planned actions, when completed subject to the clarifications below, will implement this recommendation. In its notification of final action, CMS should provide evidence of the success of the measures implemented to

decrease inaccurate and incomplete data. CMS should also provide documentation of the planned process to match enrollment data against various databases.

Attachment 2-Mcmber Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. What additional data would be valuable to help you prescreen for Medicare fraud?

The Honorable Michael C. Burgess

1. Do you have the ability to get a query of the National Practitioner Data Bank

Answer:

Gaining or modifying access to two data sources would assist OIG in pursuing exclusion actions. Gaining access to the National Crime Information Center for assistance in exclusion investigations, and modifying access to the National Practitioner Data Bank for investigation support would enhance OIG's exclusion operations.

National Crime Information Center (NCIC)

In April 2012, the Federal Bureau of Investigation terminated access to the National Crime Information Center (NCIC) for OIG's Exclusion Program. This decision was based upon DOJ/CJIS policy that does not allow an agency to run criminal history queries except for the express purpose of the "administration of Criminal Justice." As such, administrative processes, such as the investigation of exclusion matters, were deemed a disallowed purpose to run NCIC queries. However, there is legislative precedent for administrative access. For example, section 6201 of the Affordable Care Act authorized the use of background checks on prospective direct patient access employees – an administrative action related to the provision of health care.

Criminal history information is used in support of the exclusion process in a number of areas:

1. Determination of previous convictions related to health care that could form the basis for an exclusion period enhancement under 1128(c)(3)(g) of the Social Security Act.
2. Support for the aggravating factors found at 42 CFR 1001.102(b):
    i. (6) The convicted individual or entity has a prior criminal, civil or administrative sanction record;

ii. (8) The individual or entity has previously been convicted of a criminal offense involving the same or similar circumstances; and
iii. (9) Whether the individual or entity was convicted of other offenses besides those which formed the basis for the exclusion, or has been the subject of any other adverse action by any Federal, State or local government agency or board, if the adverse action is based on the same set of circumstances that serves as the basis for imposition of the exclusion.

National Practitioner's Data Bank (NPDB)

Initially, OIG used the Health Integrity and Protection Data Bank (HIPDB) as a source of information in support of exclusion actions. HIPDB contained final adverse actions taken against health care providers, suppliers, and practitioners such as civil judgments, criminal convictions, licensing actions, exclusions from Federal and State health care programs and other adjudicated actions. The OIG maintained access to HIPDB at no cost to the agency. HIPDB information was available to certain federal and state agencies (mostly law enforcement agencies) and health plans. In May 2013, under Section 6403 of the Affordable Care Act, the HIPDB became part of the NPDB in an effort to eliminate a duplication of information in both the HIPDB and NPDB. The information OIG accessed in HIPDB is now accessed (at a fee) from NPDB.

The NPDB is a confidential information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the U.S. The NPDB is administered by the Health Resources and Services Administration within the Department of Health and Human Services. Per the NPDB's website:

> The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of the professional credentials of health care practitioners, health care entities, providers, and suppliers; the information from the Data Bank should be used in conjunction with, not in replacement of, information from other sources.

Prior to the consolidation of NPDB and HIPDB, NPDB contained only medical malpractice payments made on behalf of physicians, and adverse actions relating to physicians and dentists such as licensure, clinical privilege, professional society membership actions and exclusions from Medicare and Medicaid. This information was available to hospitals and health care entities with formal peer review procedures. Adverse licensing information on health care providers, practitioners and entities was added to NPDB when Social Security Act section 1921 was implemented. The section 1921 information essentially duplicated the adverse licensure information in HIPDB and was the impetus for combining the two databanks.

Information currently collected and disclosed as permitted by the NPDB includes information on medical malpractice payments, state licensure and certification actions against health care practitioners, entities, providers and suppliers; negative actions or findings by peer review organizations and private accreditation organizations; as well as

certain final adverse actions taken by state law enforcement agencies, State Medicaid Fraud Control Units, and state agencies administering or supervising the administration of state health care programs. These final adverse actions include exclusions from a state health care program, health care-related criminal convictions and civil judgments in state court, and other adjudicated actions or decisions specified in regulations. Access to information did not change with the consolidation. Basically, queriers have access to whatever information they had access to prior to the consolidation.

Though the NPDB does not have the ability to refer potential subjects to OIG for exclusion consideration, it does provide information that could be helpful in the furtherance of exclusion investigations gained through other sources. To assist with our exclusion program, OIG would find it helpful in addition to our current access level, to gain access to all information available under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended., Additionally, the OIG would seek a waiving of the per query fee for search in the NPDB.

Access to Enhanced Data

The NPDB was originally established by Title IV of the Health Care Quality Improvement Act of 1986, Public Law 99-660. The intent of Title IV was to improve the quality of health care by encouraging State Licensing Boards, professional societies, hospitals, and other health care entities to restrict the ability of incompetent physicians, dentists, and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. These adverse actions against physicians and dentists include medical malpractice payments, certain licensure actions (to which OIG had access via HIPDB and continues to have access in the consolidated NPDB), clinical privileges, and professional society membership actions, as well as Drug Enforcement Agency controlled substance registration actions and exclusions from participation in Medicare, Medicaid, and other Federal health care programs (OIG had access to exclusions information via HIPDB and continues to have access to this information in the consolidated NPDB). Historically, OIG has been barred from the NPDB information that was not duplicated in HIPDB because the statutory and regulatory wording limits access to the original NPDB information to hospitals, professional societies with formal peer review, state licensing boards and the subject(s) of the adverse reports. Gaining information related to adverse actions would assist the OIG in identifying potential factors in support of an exclusion investigation.